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PCSS Preston	Ophthalmic User Guide

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GUIDE TO COMPLETING A GOS 1 FORM

THE FOLLOWING IS MANDATORY INFORMATION THAT NEEDS TO BE COMPLETED IN ORDER FOR THE FORM TO BE PROCESSED BY PRIMARY CARE SUPPORT SERVICES (PRESTON)

PLEASE COMPLETE THE FOLLOWING DETAILS IN BLOCK CAPITALS

PART 1 PATIENTS DETAILS

- SURNAME
- FIRST NAME
- DATE OF BIRTH
- FULL ADDRESS WITH POSTCODE
- DATE OF LAST EYE TEST

NOTE: PLEASE ENTER AN EARLY RE-TEST CODE IN PART 3 (REVERSE OF FORM) IF THE TEST HAS BEEN PERFORMED EARLIER THAN THE PERMITTED INTERVAL

GOS MINIMUM SIGHT TEST INTERVALS ARE AS FOLLOWS:

Patients Age at Time of Sight Test or Clinical Condition	Minimum Interval Between Sight Test
Under 16 years in the absence of any binocular vision	1 year
Under 7 years with binocular vision anomaly or corrected refractive error	6 months
7 years and over and under 16 with binocular vision anomaly or rapidly progressing myopia	6 months
16 years and over and under 70 years	2 years
70 years and over	1 year
40 years and over with family history of glaucoma or with ocular hypertension and not in monitoring scheme	1 year
Diabetic/glaucoma patients	1 year
Registered blind/partially sighted	2 years
Considered to be at risk of glaucoma	2 years
Prescribed Complex Lens	2 years

- PLEASE TICK RELEVANT PATIENT ENTITLEMENT.

GOS 1

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COMPLETE:

- NAME AND FULL ADDRESS OF SCHOOL/COLLEGE/UNIVERSITY IF PATIENT IS A STUDENT AGED UP TO 18
- PARTNERS FULL DETAILS IF PATIENT IS NOT THE ONE RECEIVING BENEFIT
- HC2 CERTIFICATE NUMBER (IF APPLICABLE)

PROVIDE FULL DETAILS OF THE:

- LOCAL AUTHORITY IF PATIENT IS BLIND/PARTIALLY SIGHTED
- GP IF PATIENT SUFFERS FROM DIABETES/GLAUCOMA
- HOSPITAL IF PATIENT CONSIDERED TO BE AT RISK OF GLAUCOMA BY AN OPHTHALMOLOGIST
- PRISON IF PATIENT IS A PRISONER ON LEAVE FROM PRISON

PART 2	**PATIENTS DECLARATION**

- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- ENSURE FORM IS SIGNED BY PATIENT OR PATIENTS REPRESENTATIVE
- PROVIDE DATE AND PATIENTS NAME (BLOCK CAPITALS).

PART 3	**PERFORMERS DECLARATION**

- PROVIDE DATE AND OUTCOME OF THE TEST
- VOUCHER TYPE (IF APPLICABLE)
- PERFORMERS SIGNATURE, LIST NUMBER AND NAME (BLOCK CAPITALS)
- APPROPRIATE CODE IF TEST LESS THAN MINIMUM INTERVAL
- ADDRESS WHERE SIGHT TEST TOOK PLACE (BLOCK CAPITALS) OR PRACTICE STAMP
- ADDRESS WHERE PAYMENT SHOULD BE SENT IF DIFFERENT
- CONTRACTORS AUTHORISED SIGNATURE
- CONTRACTORS NAME (BLOCK CAPITALS), LIST NUMBER AND DATE
- CONTRACTORS NAME AND ADDRESS (BLOCK CAPITALS) OR PRACTICE STAMP

GOS 1

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GUIDE TO COMPLETING A GOS 3 FORM

THE FOLLOWING IS MANDATORY INFORMATION THAT NEEDS TO BE COMPLETED IN ORDER FOR THE FORM TO BE PROCESSED BY PRIMARY CARE SUPPORT SERVICES (PRESTON)

PLEASE COMPLETE THE FOLLOWING DETAILS IN BLOCK CAPITALS

PART 1 PATIENTS DETAILS

- SURNAME
- FIRST NAME
- DATE OF BIRTH
- FULL ADDRESS WITH POSTCODE
- DATE OF PRESCRIPTION
- VOUCHER TYPE (INCLUDING ANY SUPPLEMENTS)
- PRESCRIPTION(S)
- PERFORMERS NAME, LIST NUMBER, SIGNATURE AND DATE.

GOS 3

PART 2 PATIENTS DECLARATION

- PLEASE TICK RELEVANT PATIENT ENTITLEMENT.
- NAME AND FULL ADDRESS OF SCHOOL/COLLEGE/UNIVERSITY IF PATIENT IS A STUDENT AGED UP TO 18.
- IF PATIENT IS NAMED ON A VALID HC2 OR HC3 CERTIFICATE PLEASE PROVIDE NUMBER AND THE VALUE THE VOUCHER WILL BE REDUCED BY FOR HC3
- PROVIDE THE DETAILS OF PRISON IF PATIENT IS A PRISONER ON LEAVE FROM PRISON
- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- ENSURE FORM IS SIGNED AND DATED BY PATIENT OR PATIENTS REPRESENTATIVE
- ENSURE PATIENTS NAME IS COMPLETED IN BLOCK CAPITALS

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PART 3	SUPPLIERS DECLARATION

- COMPLETE DECLARATION
- PROVIDE FULL DETAILS OF AMOUNT CLAIMED OR RETAIL PRICE IF APPLICABLE
- SIGN AND DATE THE FORM
- SUPPLIERS NAME AND ADDRESS (BLOCK CAPITALS) OR PRACTICE STAMP

PART 4	PATIENTS DECLARATION

- TICK AS APPROPRIATE I.E. NUMBER OF GLASSES, PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- PLEASE ENSURE PATIENT/ PATIENTS REPRESENTATIVE HAS SIGNED AND DATED THE FORM
- COMPLETE PATIENTS NAME IN BLOCK CAPITALS

GOS 3

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GUIDE TO COMPLETING A GOS 4 FORM

THE FOLLOWING IS MANDATORY INFORMATION THAT NEEDS TO BE COMPLETED IN ORDER FOR THE FORM TO BE PROCESSED BY PRIMARY CARE SUPPORT SERVICES (PRESTON)

PLEASE COMPLETE THE FOLLOWING DETAILS IN BLOCK CAPITALS

PART 1 PATIENTS DETAILS

- SURNAME
- FIRST NAME
- DATE OF BIRTH
- FULL ADDRESS WITH POSTCODE
- DATE OF LAST SIGHT TEST
- PLEASE TICK RELEVANT PATIENT ENTITLEMENT.
- NAME AND ADDRESS OF SCHOOL/COLLEGE/UNIVERSITY IF PATIENT IS A STUDENT AGED UP TO 18.
- IF PATIENT IS NAMED ON A VALID HC2 OR HC3 CERTIFICATE PLEASE PROVIDE NUMBER AND THE VALUE THE VOUCHER WILL BE REDUCED BY FOR HC3
- PROVIDE THE NAME OF PRISON IF PATIENT IS A PRISONER ON LEAVE FROM PRISON
- FULL REASON FOR LOSS/DAMAGE IF PATIENT 16 OR OVER

GOS 4

PART 2 PATIENTS DECLARATION

- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- ENSURE. FORM IS SIGNED AND DATED BY PATIENT OR PATIENTS REPRESENTATIVE
- ENSURE PATIENTS NAME IS COMPLETED IN BLOCK CAPITALS

PART 3 COMPLETED BY AREA TEAM/PCSS (PRESTON)

- TICK AS APPROPRIATE AND FILL IN IF APPROVAL IS REQUESTED

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PART 4 PATIENTS DECLARATION

- TICK IF REPAIR OR REPLACEMENT SERVICE PROVIDED
- ENSURE FORM IS SIGNED AND DATED
- PROVIDE DATE AND PATIENTS NAME (BLOCK CAPITALS)

PART 5 SUPPLIERS DECLARATION

- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- COMPLETE PRESCRIPTION IF LENS IS BEING REPLACED
- VOUCHER TYPE (INCLUDING ANY SUPPLEMENTS)
- TICK BOX AS APPROPRIATE TO VOUCHER VALUE
- PROVIDE FULL DETAILS OF AMOUNT CLAIMED OR RETAIL PRICE IF APPLICABLE
- SUPPLIER NAME, DATE AND SIGNATURE
- SUPPLIERS NAME AND ADDRESS (BLOCK CAPITALS) OR PRACTICE STAMP

GOS 4

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GUIDE TO COMPLETING A GOS 5 FORM

THE FOLLOWING IS MANDATORY INFORMATION THAT NEEDS TO BE COMPLETED IN ORDER FOR THE FORM TO BE PROCESSED BY PRIMARY CARE SUPPORT SERVICES (PRESTON)

PLEASE COMPLETE THE FOLLOWING DETAILS IN BLOCK CAPITALS

PART 1 PATIENTS DETAILS

- SURNAME
- FIRST NAME
- DATE OF BIRTH
- FULL ADDRESS WITH POSTCODE
- DATE OF LAST EYE TEST
- TICK IN APPROPRIATE BOX.
- PROVIDE HC3 NUMBER AND PAYMENT AMOUNT

PART 2 PATIENTS DECLARATION

- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- ENSURE FORM IS SIGNED AND DATED BY PATIENT OR PATIENTS REPRESENTATIVE
- PROVIDE DATE AND PATIENTS NAME (BLOCK CAPITALS).

PART 3 PRACTITIONERS DECLARATION

- DATE AND OUTCOME OF TEST
- VOUCHER TYPE (IF APPLICABLE)
- PERFORMERS SIGNATURE, LIST NUMBER AND NAME (BLOCK CAPITALS)
- PROVIDE FULL DETAILS OF AMOUNT CLAIMED
- ADDRESS WHERE SIGHT TEST TOOK PLACE (BLOCK CAPITALS) OR PRACTICE STAMP
- COMPLETE ADJACENT DETAILS IF RELEVANT
- PERFORMERS SIGNATURE
- PERFORMERS NAME (BLOCK CAPITALS), LIST NUMBER AND DATE
- CONTRACTORS NAME AND ADDRESS (BLOCK CAPITALS) OR PRACTICE STAMP

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GUIDE TO COMPLETING A GOS 6 FORM

THE FOLLOWING IS MANDATORY INFORMATION THAT NEEDS TO BE COMPLETED IN ORDER FOR THE FORM TO BE PROCESSED BY PRIMARY CARE SUPPORT SERVICES (PRESTON)

PLEASE COMPLETE THE FOLLOWING DETAILS IN BLOCK CAPITALS

PLEASE NOTE: PRIOR TO CARRYING OUT A DOMICILIARY VISIT YOU MUST HAVE A CONTRACT WITH THE AREA TEAM WHERE THE PATIENT RESIDES, AND PRIOR NOTIFICATION OF THE INTENDED VISIT MUST HAVE BEEN MADE TO PRIMARY CARE SUPPORT SERVICES (PRESTON).

PART 1 PATIENTS DETAILS

- SURNAME
- FIRST NAME
- DATE OF BIRTH
- FULL ADDRESS WITH POSTCODE
- DATE OF LAST SIGHT TEST

  NOTE: PLEASE ENTER AN EARLY RE-TEST CODE IN PART 3 (REVERSE OF FORM) IF THE TEST IS PERFORMED EARLIER THAN THE MINIMUM INTERVAL
- REASON WHY PATIENT CANNOT ATTEND PRACTICE UNACCOMPANIED.
- PLEASE TICK RELEVANT PATIENT ENTITLEMENT.

GOS 6

COMPLETE:

- NAME AND ADDRESS OF SCHOOL/COLLEGE/UNIVERSITY IF PATIENT IS A STUDENT AGED UP TO 18.
- PARTNERS DETAILS IF PATIENT IS NOT THE ONE RECEIVING BENEFIT.
- HC2 NUMBER (IF APPLICABLE)

PROVIDE DETAILS OF THE:

- LOCAL AUTHORITY IF PATIENT IS BLIND/PARTIALLY SIGHTED
- GP IF PATIENT SUFFERS FROM DIABETES/GLAUCOMA
- HOSPITAL IF PATIENT CONSIDERED TO BE AT RISK OF GLAUCOMA BY AN OPHTHALMOLOGIST
- PRISON IF PATIENT IS A PRISONER ON LEAVE FROM PRISON

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PART 2	PATIENTS DECLARATION

- TICK AS APPROPRIATE I.E. PATIENT OR PATIENTS PARENT, CARER OR GUARDIAN
- ENSURE FORM IS SIGNED BY PATIENT/PATIENT REPRESENTATIVE.
- PROVIDE DATE AND PATIENTS NAME (BLOCK CAPITALS).

PART 3	PRACTITIONERS DECLARATION

PROVIDE:

- DATE AND OUTCOME OF TEST
- VOUCHER TYPE (IF APPLICABLE)
- PRACTITIONERS SIGNATURE
- PRACTITIONERS NAME (BLOCK CAPITALS), DATE AND LIST NUMBER
- APPROPRIATE CLAIM DETAILS
- FULL DETAILS OF AMOUNT CLAIMED
- APPROPRIATE CODE IF TEST LESS THAN MINIMUM INTERVAL.
- ADDRESS WHERE SIGHT TEST TOOK PLACE (BLOCK CAPITAL)
- PAYMENT ADDRESS WHERE PAYMENT SHOULD BE SENT (IF DIFFERENT)
- CONTRACTORS SIGNATURE
- CONTRACTORS NAME (BLOCK CAPITALS), LIST NUMBER AND DATE
- CONTRACTORS NAME AND ADDRESS (BLOCK CAPITALS) OR PRACTICE STAMP

GOS 6